



PAPUA NEW GUINEA–WHO

Country Cooperation Strategy 2016–2020



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ABBREVIATIONS

CCS	country cooperation strategy
CDC	Centers for Disease Control and Prevention
CEO	chief executive officer
DDA	District Development Authority
DHFF	Direct Health Facility Funding
DFAT	Department of Foreign Affairs and Trade (Australia)
DOTS	directly observed treatment, short-course
DSIP	District Service Improvement Programme
EPI	Expanded Programme on Immunization
FETP	Field Epidemiology Training Programme
GDP	gross domestic product
HIS	Health Information System
HIV	human immunodeficiency virus
HSIP	Health Sector Improvement Programme
HSPC	Health Sector Partnership Committee
IPV	inactivated polio virus vaccine
LLGs	local-level governments
MDGs	Millennium Development Goals
MDR-TB	multidrug-resistant tuberculosis
MMR	maternal mortality ratio
MR	measles-rubella (vaccine)
NDOH	National Department of Health
NGOs	nongovernmental organizations
NHP	National Health Plan
NHSS	National Health Service Standards
NPO	National Professional Officer
NTDs	neglected tropical diseases
ODA	overseas development assistance
OPV	oral polio virus vaccine

PB	Programme Budget
PHA	Provincial Health Authority
PVC13	pneumococcal vaccine
SDGs	Sustainable Development Goals
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCs	urgent notifiable conditions
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USA	United States of America
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

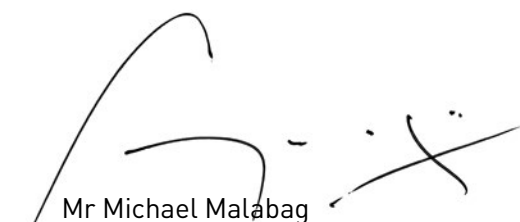


FOREWORD


The National Department of Health of Papua New Guinea and the World Health Organization (WHO) are pleased to present the *Papua New Guinea-WHO Country Cooperation Strategy 2016–2020*, which maps out priority health issues in Papua New Guinea to be addressed in cooperation with WHO over the next five years.

This country cooperation strategy (CCS) follows the midterm review of the *National Health Plan 2011–2020* and other assessments of the country situation. Papua New Guinea faces a critical transition with increased decentralization of health services, ongoing challenges in providing essential services and increasing donor challenges. This CCS is strategically focused on sustainable solutions: strengthening health security and health systems, and improving partner coordination.

On behalf of the Government of Papua New Guinea and WHO, we are thankful to everyone who contributed to this CCS. Guided by this strategy, we will work together to attain the highest level of health possible for the people of Papua New Guinea, as we strengthen health security across the Western Pacific Region and globally.



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EXECUTIVE SUMMARY

The context

The formulation of the World Health Organization (WHO) country cooperation strategy (CCS) for the period 2016–2020 follows an in-depth mid-term review of the Papua New Guinea National Health Plan 2011–2020, which indicates the need for identifying and implementing priorities, given slow progress against expected outcomes. The review stresses the importance of focusing on making rural health services functional, which will require improved management of both financial and human resources at district level and below. In the absence of a mid-term evaluation of the current CCS, the formulation of the 2016–2020 CCS takes into account the findings and recommendations of the 2013 performance assessment of WHO's role and functions in Papua New Guinea, as well as numerous reports and assessments of individual aspects of Papua New Guinea's health system.

Importantly, the CCS renewal takes place at a critical time in Papua New Guinea when a number of changes and challenges are facing the country in general and the health sector in particular. These include: the introduction of severe cuts in the national budget; a new Organic Law decreeing further decentralization from the provincial to the district level; one of the worst droughts in Papua New Guinea's history; a continuing human resources for health crisis; difficulty in making headway with immunization rates and reducing maternal mortality; and increasing donor fatigue.

The strategic agenda

With a view to being more strategic and selective than in the past, the strategic agenda covers four broad-based strategic priorities, each with a number of defined focus areas.

In terms of the first strategic priority, achieving sustainable health outcomes, the CCS aims to concentrate on addressing tuberculosis (TB), which remains a major public health crisis in Papua New Guinea, as well as the issue of TB–HIV coinfection. Another focus is immunization in light of Papua New Guinea's poor record in this area, and concerns about heavy reliance on immunization campaigns with subsequent lack of outreach services and poor vaccine management. The third focus area is reducing maternal and newborn mortality, given that Papua New Guinea's maternal mortality ratio is among the highest in the world. More needs to be done to provide quality support before, during and after pregnancy, including improved access to emergency obstetric care.

The second strategic priority, strengthening health systems, is considered by many to be the most important element of the strategic agenda. It covers strengthening

district health systems, focusing on improved service delivery at rural facility level. This includes addressing issues of flow of funds to the front line and provision of supportive supervision. Human resources for health are facing a crisis that hampers access to and quality of services, and are thus a major focus area for cooperation. Access to essential medical products and the health information system will also be addressed under the umbrella of health systems strengthening.

Emergency preparedness, surveillance and health security is the third strategic priority and includes both disaster preparedness and response, as well as surveillance and epidemics. Work in surveillance and epidemics will entail continuation of the Field Epidemiology Training Programme and enhancement of national surveillance capacity. Disaster preparedness and response is about strengthening the capacity of the National Department of Health (NDOH) in disaster risk management.

The fourth strategic priority is sector overview, policy dialogue and development cooperation, and is based on WHO's leadership role and responsibility in providing sound and coherent policy advice based on a comprehensive overview of the health sector, and on ensuring effective development cooperation. It also includes strategic communication as a focus area to show that health is a key part of national development.

The challenge of implementation: implications for the WHO Secretariat

Apart from outlining the required changes in the mix and profiles of professional staff, and relating CCS priorities to programme budget activity costs and staff numbers (see Table 3 of the main text), a number of issues and challenges are highlighted. These include:

- placing the best people in the most demanding jobs, as one of the core principles for keeping countries at the centre of WHO's work, to be put into practice;
- providing country-focused and demand-led support from the WHO Regional Office for the Western Pacific and WHO headquarters;
- exploring the use of external resource institutions and consultants for additional support;
- encouraging greater teamwork, particularly the interaction between health outcomes and health systems programmes of work;
- strengthening the WHO Representative Office to perform the leadership and overview function that is part of WHO's local and global role; and
- ensuring that the CCS is a "live document" by regularly reviewing progress made and lessons learnt, including a sound mid-term evaluation.





1. Introduction

The World Health Organization (WHO) country cooperation strategy (CCS) for Papua New Guinea sets out the strategic agenda for WHO's cooperation with the Government of Papua New Guinea over the next five years (2016–2020).

The CCS is based on a systematic review of the country's health needs and goals, based on the 2011–2020 National Health Plan (NHP) and on the findings and recommendations of the recent mid-term review of the NHP, as well as other documents that describe and assess the current situation in Papua New Guinea. It takes into consideration contributions by all development partners, including nongovernmental organizations (NGOs), in support of health development in Papua New Guinea. The strategic agenda has been developed in a highly consultative process involving national and international stakeholders. A list of people consulted is appended as Annex 1.

The global development framework that informs action by nations is moving on from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs). Importantly, in Papua New Guinea, the MDG agenda is unfinished and remains crucial during this transitional stage.

The broader country context and Papua New Guinea's current health and development challenges are outlined in Chapter 2, including an overview of development cooperation in the health sector. Chapter 3 briefly reviews WHO cooperation during the period of the previous CCS 2010–2015, and discusses some of the constraints encountered. The core of the document is Chapter 4, which presents the strategic agenda for 2016–2020. The timing coincides with the second half of the period covered by Papua New Guinea's NHP, and is formulated under the overarching umbrella of universal health coverage (UHC). Chapter 5 considers the implications of the proposed strategic priorities and

focus areas for the work of the entire WHO Secretariat, led by the country office but supported, as required, by the WHO Regional Office for the Western Pacific and WHO headquarters.

The CCS aims to be focused and selective, setting strategic priorities rather than covering the entire spectrum of WHO's activities. It is intended to be a "live document" and a dynamic tool to guide planning and implementation. An in-depth mid-term review is planned for 2018-2019 to ascertain the continuing relevance of the strategic agenda, and to agree on adjustments and adaptations based on lessons learnt during the first half of the period covered by the CCS.



2. Health and development challenges

Papua New Guinea has a total of 841 listed languages, a land mass of 462 840 km², and is divided into 22 provinces, 89 districts and 4 regions. Each of the districts is subdivided into local-level government (LLG) areas and these in turn are divided into wards. In line with the Organic Law on Provincial and Local Level Government, the Government established District Development Authorities (DDAs) in 2015. Under the Expanded District Services Improvement Programme, funding decisions are devolved to the DDA.

The country has 7.06 million inhabitants, an annual growth rate of 2.8% (2000–2011) and a largely rural (87.5%) population. The average life expectancy is 63.2 years. Forty per cent of the population is aged under 15 years.

Papua New Guinea enjoyed a decade of near-uninterrupted economic growth averaging 5.4% annually, mainly owing to its still-growing mining industry and investments in the oil and gas sector. In 2012 Papua New Guinea was the tenth fastest growing economy globally. The gross domestic product (GDP) per capita was estimated to be US\$ 2000. Based on these growth figures, the Government projected that spending on health care and education, training and law and order would increase, on average, by 50% in 2013. In 2014, the Government of Papua New Guinea passed an annual budget of US\$ 5.4 billion, the largest in the country's history. This resulted in the allocation of substantial direct funding to the provincial and district governments.

Owing to the impact of the recent global fall in gas and oil prices, the 2015 budget appropriation to government departments was revised downwards. As a result, the budget appropriation for the National Department of Health (NDOH) was slashed by close to 300 million kina (PGK). It is projected that government expenditures across the board will contract by 30% over the period 2016–2018. Australia's Department of Foreign Affairs and Trade (DFAT), which is Papua New Guinea's largest donor, has projected a 5% reduction in its overseas development assistance (ODA) to Papua New Guinea.

Health governance and health policy reforms

National Health Plan

The NHP 2011–2020 is the sole governing policy document for the health sector in Papua New Guinea. It sets out the strategic direction and priorities for both the public and private sectors. The NHP is implemented through medium-term plans at the national and provincial levels. These are translated into operational annual implementation plans at all levels of the health system.

Health service delivery platform

The National Health Services Standards (NHSS) of 2011 redefined Papua New Guinea's service delivery platform into seven levels:

- level 1 – the aid post;
- level 2 – the community health post;
- level 3 – the rural and urban health centres;
- level 4 – the district hospital;
- level 5 – the provincial hospital;
- level 6 – the regional hospital; and
- level 7 – the national referral hospital (Port Moresby General Hospital).

Levels 1 to 4 constitute Papua New Guinea's "rural health services". The NHSS incorporate role delineation within the service delivery platform; define minimum standards for essential medical and non-medical equipment; minimum health workforce requirements; clinical guidelines; health facility design standards; and a health service accreditation programme.

About 50% of the health service delivery, mostly in the rural areas, is provided through church health services. These services are subsidized by the Government through annual Church Health Services Operational Grants from the NDOH.

The Provincial Health Authority and District Development Authority

The Provincial Health Authority Act of 2007 establishes Provincial Health Authorities (PHAs), which integrate the management of hospital and rural health services under one authority. Where provinces opt to establish a PHA, the staff of hospital services and rural health services are accountable to the chief executive officer (CEO) of the PHA. In provinces without a PHA, hospitals are managed by the NDOH and rural health services fall under the ambit of the provincial government. In a major policy development in 2015, the Government of Papua New Guinea established the DDA as another layer of decentralization. While work is still ongoing to define roles and responsibilities within the DDA, the National Executive Council has directed the NDOH to develop strategies to ensure complementarity of roles and responsibilities between the PHA and DDA in health service delivery.

Health financing

Health budget

Funding streams for rural health services include health function grants to provinces, provincial internal revenue, Church Health Services Operational Grants funds from the Health Service Improvement Program (HSIP), and District Service Improvement Program (DSIP) and revenue from user fees. DSIP funds are allocated to members of parliament for district development programmes, including health infrastructure. These funds are outside the direct control of civil servants, often resulting in development projects that are implemented separately from provincial and district development plans.

The Papua New Guinea health budget has historically remained below 4% of the GDP. Papua New Guinea's government expenditures on health increased from PGK 137 per capita in 2011 to an estimated PGK 257 per capita in 2015. The main beneficiaries of these increases were the NDOH and hospital services, at the expense of rural health services and public health programmes. Total recurrent spending on rural health increased from PGK 12 million in 2005 to PGK 64 million in 2012. Churches received an increase of 23% whereas NDOH and hospital services received a 66% increase in their allocations.

Abolition of user fees

Bottlenecks in the flow of funds to front-line service delivery facilities have over the years compelled primary health care facilities (both church- and government-funded) to raise operational funds from user fees. In 2013, the Government adopted the "free primary health care and subsidized specialist services policy", which effectively barred primary health facilities from charging user fees. To "compensate" these facilities for this loss of revenue, the Government of Papua New Guinea has allocated PGK 20 million per year to be distributed to all facilities affected by this policy.

Health funds not reaching front-line service delivery

Different funding sources often result in different plans, with inconsistencies that make implementation difficult. Bottlenecks in the financing system often result in delayed payments, uneven spending patterns and funds not reaching front-line service delivery. Although most provinces now receive increased health function grants, resources are still insufficient to cover the minimum cost of basic rural health services. Provincial governments prioritize funding the costs of health administration over service delivery. This results in persistently low spending by provinces on recurrent operational health costs such as medical supplies, distribution of medicines, facility maintenance, and fuel and travel for outreach patrols and supervisory visits. Limited absorptive capacity to spend increased resources is possibly the largest constraint, and this is unlikely to change unless attempts are made to improve implementation capacity.

Direct health facility funding

A district case study conducted in 2009 identified a number of reasons why funds were not reaching the facility level and recommended the trial of direct health facility funding (DHFF). In 2011, NDOH piloted DHFF in one province. Participating facilities had to stop charging user fees, open bank accounts and receive funding directly into these accounts. An independent evaluation of DHFF found it to be a viable policy option to improve fund flows to health centres and noted that the majority of health centres that had stopped levying user fees “provided a higher number of primary care services”. However, to date the system has not been adopted in other provinces and districts.

Health outcomes and services

Poor health outcomes

Papua New Guinea’s progress towards the MDGs has been at best sluggish and uneven across the country. As Papua New Guinea adopts the new SDGs it must be noted that, as a country, Papua New Guinea had not achieved any of the MDGs by the end of 2015.

The provinces with the highest levels of early childhood mortality also have low levels of immunization coverage. National immunization rates have declined to as low as 43% for measles vaccination and 52% for the third dose of the pentavalent vaccine (Sector Performance Annual Report, 2013). In 2014 Papua New Guinea experienced a measles outbreak with a cumulative total of 34 344 clinically suspected cases and 312 reported deaths. According to the National Health Information System (HIS), 25% of children under the age of 5 years weigh less than 60% of the average weight for their age. The Household and Income Expenditure Survey (2010) indicated that 45.2% of children were stunted, 14.3% wasted and 24.8% underweight.

The burden of disease in Papua New Guinea is largely dominated by communicable diseases such as pneumonia, tuberculosis (TB) and diarrhoeal diseases, but the prevalence of noncommunicable diseases is rapidly increasing. Diabetes and ischaemic heart disease are moving up into the top five leading causes of deaths in Papua New Guinea, a clear indication of the increasing prevalence and importance of noncommunicable diseases.

Papua New Guinea experienced a decline in the incidence of malaria from 316 per 1000 in 2006 to less than 236 per 1000 in 2010. Population surveys conducted by the Papua New Guinea Institute of Medical Research (2013–2014) indicate a sharp decrease in malaria prevalence from 12.4% to 1% and a decrease in crude malaria incidence from 205 per 1000 population to 48 per 1000. This trend has been attributed to the introduction and widespread use of insecticide-treated bed nets and the availability of rapid diagnosis and anti-malaria treatment.

TB remains a significant public health problem with national indicators showing stagnating and, in some provinces, declining treatment success rates. Multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) are on the increase, especially in Western Province.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) report for 2012, HIV infections in Papua New Guinea have decreased by more than 25% since 2001. HIV prevalence has remained below 1%. There is increasing evidence that HIV in Papua New Guinea has moved from being a generalized epidemic to a more concentrated one.

Estimates for Papua New Guinea's maternal mortality ratio (MMR) are disputed. The H4 (WHO, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank (2010)) indicate an MMR of 230 per 100 000 live births. The Papua New Guinea Demographic Health Survey (2006) gave an estimate of 733 per 100 000 live births. A more recent estimate by the School of Medicine and Health Sciences, University of Papua New Guinea, using a combination of tools, is 545 per 100 000 live births. Coverage rates for supervised deliveries remain at about 42% of expected deliveries. The contraceptive prevalence rate is 32% with an unmet need for family planning (2010) of 27% (WHO, 2014).

Accessing and utilizing health services

Difficult terrain and a lack of road infrastructure and transport contribute to the high cost of delivering services, and hinder patient referrals and supervisory visits. Persistent law and order problems disrupt effective service delivery, prevent the utilization of health services and prevent health personnel from taking assignments, leading to staff absences and closure of health facilities. Although the context is different in every province, the integrated nature of facility services and outreach patrols means that health indicators are heavily influenced by common system-wide factors. Therefore improving one function in isolation will not necessarily impact overall service delivery performance.

Too few health workers

With a health worker density of 0.58 per 1000 population, Papua New Guinea is experiencing a health workforce crisis. The NHP (2011–2020) did not take into account the cost implications of the health workforce required for its full implementation. The review of the human resources for health situation by the World Bank (2011), *Papua New Guinea health workforce crisis: A call for action*, calls for urgent action to “redress the supply and demand imbalances arising from: (a) the current severely constrained training system for new health workforce cadres; (b) the rapid aging of the existing workforce; and (c) the expanding demand for services over the next 10 to 20 years that arises from sustained increase of the population”. The Government developed a Health Workforce Enhancement Plan (2013–2016) as an interim strategy. Plans to increase the retiring age of health workers are at an advanced stage; retired health workers are now being employed on short-term contracts; and the Government has allowed expatriate health workers to be employed in the public health sector. The human resources for health strategic plan is expected to be developed in 2016.

Facilities lack basic medicines

An evaluation of the availability of essential medicines and supplies conducted in 2013 showed that 64% of selected tracer medicines were in stock. In 2014–2015 the NDOH embarked on a scheme for the distribution to peripheral health facilities across the country of selected essential medicines and supplies through the so-called 100% Kit. While the 100% Kits did not necessarily meet the exact needs at the health facility level, the distribution did result in important medicines being available in most facilities. However, unreliable and incomplete data and poor stock management practices continue to contribute to increasing waste of supplies (expiry, damage, leakages) and stock-outs. Provinces do not allocate adequate resources for the distribution of medicines and lack the logistic capacity to manage a complex system for ordering and distribution to facilities. The roll-out of the Logistics Management Information System is expected to improve real-time reports of end-user consumption as well as quantification and forecasting of the need for medicines and other supplies in the public health sector. Challenges remain in addressing medicines quality control and regulation. Work is ongoing on the construction of a pharmaceuticals quality assurance laboratory and the development of a regulatory framework.

Deteriorating infrastructure

Decades of underfunding of provinces by national government and low prioritization for maintenance have contributed to chronic neglect of infrastructure. Health facilities without a consistent supply of running water, adequate sanitation, after-hours lighting and basic equipment are common. There is a tendency to build new facilities instead of renovating existing ones. Insufficient and inadequate housing for staff and their families, and concerns about employment conditions, further erode the motivation of staff.

Development cooperation

In 2015, the Government of Papua New Guinea adopted the Papua New Guinea Development Cooperation Policy (2015–2017), which provides a clear direction and defines protocols of engagement between the Government of Papua New Guinea, development partners, provinces, the private sector and civil society organizations in mobilizing, coordinating and managing development assistance. The annual High Level Forum between the Government of Papua New Guinea and development partners and the quarterly Joint Technical Working Group on Development Effectiveness are some of the mechanisms for consultations and policy dialogue. Health development partners convene monthly coordination meetings to build consensus on issues that arise between partners as well as with the Government. The Country Coordination Mechanism monitors implementation of activities supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The United Nations Resident Coordinator (RC) chairs the United Nations Country Team (UNCT) which consists of heads of UN agencies. Delivering as One is the United Nations initiative that brings together UN agencies to enhance efficiency, effectiveness and

coherence in their support to governments. The United Nations Development Assistance Framework (UNDAF) 2012–2015, extended until 2017, is the current joint programme for UN support to Papua New Guinea, with WHO, UNICEF and UNFPA collaborating in the UN Health Task Team.

According to Papua New Guinea's largest donor, DFAT Australia, Papua New Guinea's decade of economic expansion has resulted in a reduction in the amount of Australian aid. While in 1975 Australian aid represented 40% of Papua New Guinea's budget, by 2015 this proportion had decreased to about 8%. Australian development assistance in Papua New Guinea currently constitutes approximately 68% of Papua New Guinea's total ODA. A significant amount of funding for UN agencies in Papua New Guinea is provided by DFAT. The Australian Aid programme continues to provide priority investments in improving health, education, infrastructure and law and order. A total of 181 advisers, including a significant number in health, were phased out in 2012 and this trend will continue into 2016.

Table 1: Total ODA for all donors

Donor	2011		2012		2013	
	Spending (millions of US\$)	Percentage of total ODA	Spending (millions of US\$)	Percentage of total ODA	Spending (millions of US\$)	Percentage of total ODA
Australia	520.3	77.5	498.6	70.2	474.2	67.7
Asian Development Bank	13.1	2.0	60.2	8.5	87.7	12.5
Global Fund	13.6	2.1	36.2	5.1	35.1	5.0
International Development Association	17.6	2.7	27.0	3.8	26.7	3.8
New Zealand	25.7	3.9	24.3	3.4	19.1	2.7
Japan	34.1	5.2	21.7	3.0	11.4	1.6
European Union	19.9	3.0	15.6	2.2	8.0	1.1
United States of America	3.6	0.5	3.6	0.5	7.3	1.0
Organization of the Petroleum Exporting Countries	–	0.0	0.0	0.4	6.9	1.0
Gavi	0.7	0.1	1.4	0.2	6.3	0.9
All other donors	19.8	3.0	19.2	2.7	17.6	2.7
All donors, Total	685.4	100	710.6	100	700.3	100

Source: www.dfat.gov.au/geo/papua-new-guinea/development-assistance/pages/papua-new-guinea.aspx



3. Review of WHO cooperation 2010–2015

At the time the WHO CCS was developed in 2009, the current NHP for 2011–2020 was in preparation but not yet completed. A number of reforms were in the making, among them the establishment of PHAs, but had not yet been fully developed and agreed. Hence, the strategic agenda put forward in the CCS was largely based on priorities of the previous NHP (2001–2010) as well as on information and views obtained during extensive consultations with the NDOH and a wide range of key stakeholders.

An external assessment of WHO's performance of its roles and function in Papua New Guinea – largely focusing on WHO's ways of working – was conducted in 2012. The assessment suggested that the main strategies of the CCS remained relevant, although "there was a perception among the current executive management of the NDOH that it was developed without sufficient consultation and may not fully reflect current priorities". It indicated that a mid-term adjustment in view of a rapidly changing environment and the election of a new government should be considered. However, in the event, no mid-term evaluation of the CCS was carried out.

Numerous activities were carried out under Strategic Priority 1, WHO's traditional domain of technical and programmatic work. Key achievements include the establishment of the Papua New Guinea Field Epidemiology Training Programme (FETP) and the training of more than 400 midwives as part of the strategy to reduce maternal mortality. Significant time, material resources and staff efforts were invested in strengthening routine immunization and in controlling the measles epidemic that claimed the lives of more than 312 children in 2014.

2010–2015 strategic priorities

Four strategic priorities were identified in the 2010–2015 CCS.

- Strategic Priority 1:** Technical excellence for sustainable health outcomes focused on the prevention and control of communicable and noncommunicable diseases as well as on improving maternal and child health.
- Strategic Priority 2:** Technical support to health systems strengthening covered a wide range of activities, including not only human resource development and medical supply reform, but also support to core capacities of the NDOH and government oversight of private and non-state providers.
- Strategic Priority 3:** The main thrust was on universal access to primary health care, and on supporting NDOH engagement with provinces and districts.
- Strategic Priority 4:** Sector overview, partnerships and aid effectiveness concerned policy dialogue, tracking of resource allocation, policy action and results, as well as strengthening and consolidating partnerships and WHO's role within the aid effectiveness agenda.

While the current NHP does not prioritize neglected tropical diseases (NTDs), these were included in the CCS mainly because they were a priority in the 2001–2010 NHP. In relation to strategic priorities 2 and 3, key activities included support for the development of a monitoring and evaluation strategy and performance assessment framework for the NHP and for the implementation of Papua New Guinea's pharmaceutical reforms, in particular, strengthening drug regulation and quality assurance. The institutionalization of National Health Accounts was another core activity.

Several activities were implemented outside the CCS strategic priorities, including support to strengthening laboratory services, civil registration and vital statistics, establishment of hospital-based cancer registries, e-health, and blood transfusion services. This was partly because some of these activities were part of global initiatives, adhoc requests from NDOH programme managers and, in some cases, because additional funding was made available. Some planned activities were deferred for reasons that include the unavailability of qualified staff within the country office as well as changing priorities of national health authorities.

Under Strategic Priority 4, WHO provided leadership and chaired a number of important committees and meetings, including the Health Cluster of the UNCT, and (as co-chair with DFAT) the monthly health development partners' consultative meetings. WHO also represented donors in the Health Sector Partnership Committee (HSPC), a high-level policy dialogue forum between health donors, central government agencies, representatives of NGOs and other non-state providers of health services. The HSPC was, however, abolished in 2014, which is symptomatic of the difficulties associated with policy dialogue and partnership implementation in Papua New Guinea.

Some of the directions and ambitions outlined under Strategic Priority 4 did not come to fruition, not least because, during the period under review, WHO experienced severe staff shortages and was unable to recruit senior staff with the requisite profile for upstream analytical and advocacy work.

Funding

WHO's major funding partner in Papua New Guinea is the Australian Government through DFAT. Funding agreements between WHO and DFAT include the WHO-DFAT Partnership Funding (2012-2016) and the Maternal and Child Health Initiative (2011-2013). The WHO-DFAT Partnership Funding provides predictable funding to the WHO country office to address a critical funding gap and supports mutually agreed priority areas for which WHO has a comparative advantage. Thirty-one per cent of the budget covers staff costs for a number of key positions in the country office, and 69% of the funds were designated for programme costs.

Staffing

High staff turnover and difficulties in filling professional staff vacancies adversely affected implementation of planned activities. A number of critical professional staff positions remained vacant, including the position of Programme Management Officer, resulting in increased pressure and a heavier workload for existing staff.

The staffing situation is slowly improving, although several critical issues remain. These are discussed in Chapter 5, which outlines a number of challenges and considers opportunities for making improvements in the work of the WHO country office in relation to the implementation of the 2016-2020 CCS.

Some lessons learnt

- A mid-term evaluation in 2012-2013 would have been useful for reviewing the continuing relevance of the CCS strategic priorities and to make adjustments accordingly, particularly since the NHP was completed after the WHO CCS was produced. Significant changes in the country context should also signal the need to review jointly with NDOH and development partners the changes in development cooperation that would be needed to address new challenges and directions.

- The WHO country office cannot be effective without qualified, experienced and appropriately oriented staff in key positions. Support from other levels of WHO can help, but needs to be of sufficient depth and continuity to achieve the desired impact on country operations.
- Although the 2010–2015 CCS referred to more strategic selectivity in WHO’s activities, this remained an elusive goal. Greater efforts need to be made in 2016–2020 to adhere to this principle to achieve a greater impact in fewer but more intensified areas of work.



4. The strategic agenda

The strategic agenda, covering four strategic priorities and 12 focus areas, has been formulated based on extensive consultation with the NDOH, development partners, including NGOs, churches, and private-sector foundations, and of course WHO staff. An in-depth analysis of the current country context, the review of the recent mid-term evaluation of the NHP 2011–2020, as well as lessons learnt from the implementation of the previous CCS and the findings of a WHO Performance Assessment, have informed the strategic agenda. Consideration has been given to WHO’s comparative advantage in providing technical support and policy advice, the activities of other development partners and the capacity of the WHO country office coupled with anticipated support from WHO’s Regional Office and headquarters.

Papua New Guinea is going through a period of considerable change and faces many challenges. Following a decade of unprecedented economic growth, the global financial crisis and falling commodity prices have resulted in severe budget cuts. The economic challenges are compounded by one of the worst droughts in Papua New Guinea’s history. This has a negative impact on the health sector, which is already facing a crisis in human resources for health, increasing donor fatigue, as well as difficulties in making headway with immunization rates and in reducing maternal and newborn mortality. Papua New Guinea also has to deal with the new legislation which will decree further decentralization to the district level with the creation of DDAs.

The strategic agenda is embedded within the broader visions and values promoted by the international community, including respect for human rights, equity and gender as fundamental principles. By the same token, UHC represents the overarching goal for health, and its attributes inform both policy and implementation.

It is important to note that the strategic agenda does not include everything that WHO does or is going to do. WHO will continue with a number of ongoing activities outside the CCS strategic priorities and provide technical support as the need arises. However,

the CCS does adopt and promote the principle of strategic selectivity, recognizing that WHO cannot do everything that pertains to health and the health sector, and that it will be spreading itself too thinly if it does so. The CCS also represents an opportunity to effect shifts in focus in line with the changing requirements of Papua New Guinea's health system as well as with regional and global priorities.

A mid-term review of the CCS is planned for 2018–2019, and strategic priorities may alter depending on the findings. A likely example is noncommunicable diseases, which are currently not included, but with the present trend continuing, it is anticipated that they will be added to the strategic priorities and the requisite human and financial resources will be identified.

In assessing the impact of WHO's present and intended work, it is important to keep in mind that not all aspects can be measured, even when the bottom line is changes in health outcomes and health systems' functioning. Some of the most important functions – exercising influence, providing leadership and building institutional and individual capacity – are difficult to quantify and yet are critical to technical cooperation with the Government of Papua New Guinea.

Table 2 provides an overview of the strategic priorities and focal areas briefly described in the subsequent pages.

Table 2: Overview of strategic priorities and focus areas

<p>Strategic Priority 1 Achieving sustainable health outcomes</p>	<p>Focus Area 1: TB/HIV Focus Area 2: Immunization Focus Area 3: Reducing maternal and newborn mortality</p>
<p>Strategic Priority 2 Strengthening health systems</p>	<p>Focus Area 1: District health systems strengthening Focus Area 2: Human resources for health Focus Area 3: Access to essential medical products Focus Area 4: Health information system</p>
<p>Strategic Priority 3 Emergency preparedness, surveillance and health security</p>	<p>Focus Area 1: Disaster preparedness and response Focus Area 2: Surveillance and epidemics</p>
<p>Strategic Priority 4 Sector overview, policy dialogue and development cooperation</p>	<p>Focus Area 1: Policy dialogue and implementation Focus Area 2: Effective development cooperation Focus Area 3: Strategic communication</p>

STRATEGIC PRIORITY 1

Achieving sustainable health outcomes

FOCUS AREA 1: TB/HIV

As TB remains the major public health problem in Papua New Guinea, WHO will continue its long-standing support to the National TB Control Programme. With the rapid emergence of MDR-TB, an already difficult situation now poses additional urgent challenges. Apart from the focus on TB-HIV coinfection, WHO will continue to provide support to address the challenges related to HIV/AIDS, within the context of a shift towards a concentrated HIV epidemic and a slowly decreasing prevalence.

WHO support will encompass the following:

- Supporting the National Strategic Plan for Tuberculosis 2015–2020. WHO will emphasize strengthening of the basic directly observed treatment, short-course programme aimed at reducing the disease burden and preventing development of resistance. In line with the National Strategic Plan for Tuberculosis, WHO will coordinate and provide technical guidance for its implementation, assist in capacity-building and monitor progress through periodic review and regular cohort data analysis. WHO will also promote operational research capacity to address the questions raised in the TB programme and adaptation of the policy based on the evidence generated.
- Holistic approach to emergency response for MDR-TB. The emergence of MDR-TB compounds the TB problem and is a major health issue in Papua New Guinea's Western Province and in several other hotspots in the country. The MDR-TB outbreak is evidenced by increased case notification over the past five years and high rates of person-to-person spread or primary transmission. The situation is further complicated by emerging cases of XDR-TB. Currently, as Secretariat to the M/XDR-TB Emergency Response Team led by the Deputy Secretary of NDOH, WHO plays an important role in the coordination of the MDR-TB response. WHO will coordinate and provide technical support for the development of a functional national MDR-TB model. In addition, WHO will support the implementation plan of the Western Province, provide regular supervision, periodically review progress, identify major gaps and advise on necessary updates of the plan. Furthermore, WHO will play a proactive role in the rational introduction of new tools and medicines.
- Focus on populations most at risk for HIV. The most recent evidence indicates that rather than being generalized, the HIV epidemic in Papua New Guinea is concentrated in certain geographical locations and key population groups (sex workers, men who have sex with men and transgender people). Within this changing

HIV landscape and in line with the National HIV/AIDS Programme strategy, WHO will focus on the coordination and provision of technical assistance for strengthening prevention, testing, treatment and care, including TB-HIV collaboration, and support services for the key populations. Special attention will be paid to strengthening the national HIV surveillance, particularly related to key populations, and to expanding operational research capacity. Given the increasing national ownership of the HIV response and the strengthening of national capacity for its implementation, it is anticipated that WHO's role will gradually shift from the current hands-on approach to a more strategic and coordinating role, reducing the need for in-country support.

FOCUS AREA 2: Immunization

In 2014, 10 out of 22 provinces reported immunization coverage for pentavalent vaccine third dose at under 50%, suggesting that of the total target population of infants under 1 year of age, currently almost half of those infants are incompletely immunized. This figure may be higher depending on the population denominators used. Despite many years of technical and financial support to the Expanded Programme on Immunization (EPI), recent reviews have identified a wide range of problems including heavy reliance on immunization campaigns with subsequent lack of outreach services, poor vaccine management, frequent interruption of vaccine supply, lack of supportive supervision for health centre staff, and poor surveillance for vaccine-preventable diseases.

With support from Gavi, the national immunization schedule for 2015 now includes three new vaccines: measles–rubella (MR), pneumococcal vaccine (PCV13), and inactivated polio virus vaccine (IPV). The top priority for the next five years will be to support the implementation of an effective routine immunization programme that ensures that all children receive timely routine doses of these vaccines in addition to the other vaccines (Bacillus Calmette–Guérin (BCG), hepatitis B vaccine, oral polio virus vaccine (OPV) and pentavalent vaccine), with a targeted immunization coverage of > 90%.

Over the next five years, WHO will support the Government with:

- implementing the global vaccine action plan, with emphasis on strengthening service delivery and immunization monitoring in order to achieve the goals for the Decade of Vaccines;
- strengthening of country capacity in surveillance and use of immunization data for programme monitoring and reporting;
- developing and implementing national strategies for measles, rubella, neonatal tetanus and hepatitis B immunization, including support for evidence-based policy-making and legal frameworks to implement national strategies on measles elimination, rubella elimination and congenital rubella syndrome prevention, neonatal tetanus elimination and hepatitis B control;

- maintaining the polio-free status of the country, covering planning and implementation of OPV2 withdrawal and IPV introduction, and conducting regular risk analysis in areas at high risk of polio importation and outbreaks and circulating vaccine-derived poliovirus emergence;
- in collaboration with UNICEF, providing support to cold chain system and vaccine management and regulation.

FOCUS AREA 3: Reducing maternal and newborn mortality

Maternal, newborn and child health refers to an integrated continuum of care that delivers basic services to mothers and infants at critical points, and to children in their first five years of life. The survival of women and newborns in childbirth is a sensitive marker of a health system's capacity to respond to health needs.

The Papua New Guinea MMR is among the highest in the world according to best estimates, controversy over the most accurate figure notwithstanding. WHO will focus on addressing maternal and newborn mortality. For far too long, rates of skilled birth attendance and antenatal care coverage have remained low. The underlying cause is largely explained by poor access to essential health services. A range of policies, strategies and clinical standards has been developed, but these have not been translated into operational plans in provinces and districts as the basis for sustained implementation.

WHO will work with government and development partners to provide technical guidance, combining technical and programmatic interventions with health systems strengthening (see Strategic Priority 2), focusing on programme interventions that cover both prevention and treatment, e.g. guidelines and standards; staff training; standard operating procedures; monitoring and supervision; and overall technical capacity to provide services.

Specifically, WHO will support:

- continued capacity-building to provide safe and supervised deliveries, and quality support before, during and after pregnancy, including early and essential newborn care;
- improving access to emergency obstetric care;
- ensuring improved and effective practice of maternal death surveillance and audits;
- promoting and supporting involvement of communities by engaging and networking with NGOs and community-based institutions to identify and address the demand factors;

- linking up with health system strengthening that focuses on building leadership, management capacity and a culture of accountability; and
- coordinating family planning inputs with relevant partners.

Other area of work: malaria surveillance

Although not a strategic priority, malaria deserves to be mentioned here. The malaria programme has experienced remarkable success in the past decade and has had a substantial health impact. During the coming five years, WHO will focus its support on consolidating and further extending achievements in malaria control by strengthening the malaria surveillance systems. In the high- and moderate-transmission settings, the initial phases of building an effective surveillance system will focus on ensuring good quality data. In addition, WHO will provide further technical support to pilot the establishment of the malaria surveillance system in low-transmission areas for moving towards the pre-elimination of malaria in one or two provinces where case-based surveillance will be introduced.

STRATEGIC PRIORITY 2:

Strengthening health systems

WHO will support the implementation of governmental and health sector reforms which include the roll-out of the PHA, building the capacity of the DDAs to deliver health services, health workforce planning, and management and implementation of the Free Primary Health Care and Subsidized Specialist Services Policy. The aim of the support will be to strengthen the leadership and stewardship role of the NDOH and to develop of a core set of functional and structural elements that guarantee universal coverage and are equity enhancing. This requires a sound legal, institutional and organizational foundation. In this evolving context, the district health system will be the cornerstone of Papua New Guinea's improved health delivery system.

FOCUS AREA 1: District health systems strengthening

WHO will assist NDOH efforts to revise health policies to address the changing health environment, strengthen its stewardship and leadership role, and its capacity to coordinate partnerships in health development. In light of the introduction of the DDAs, WHO will support NDOH to develop and implement strategies and mechanisms to achieve complementarity and coherent links between the PHA and DDAs. As part of this new way of working, WHO will support the NDOH, provincial and district authorities in developing a culture of accountability. Central to this support will be the development of a phased approach to district health systems strengthening in selected districts, and sharing experiences with other districts as well as with different policy forums and partnership groups.

WHO will collaborate with the World Bank and other development partners to support effective mechanisms to improve flow of funds to front-line health service delivery. The results of ongoing analytical work on determining the cost of service delivery at different levels of the system will be an important input to improve resource allocation to rural health facilities.

Assistance will be provided to enhance the implementation of the Free Primary Health Care and Subsidized Specialist Services Policy. WHO will also continue its support for the institutionalization of National Health Accounts in Papua New Guinea, and promote the use of information from National Health Accounts for decision-making.

FOCUS AREA 2: Human resources for health

By all estimates, Papua New Guinea is faced with a severe shortage of health sector workers. Despite emergency hiring efforts to recruit expatriate health workers, the lack of a strategic plan for human resources and a robust human resources information system means that the situation remains dire. This crisis in human resources for health has hampered efforts to improve the quality of care and has contributed to inequities in access to services, ultimately resulting in avoidable morbidity and mortality.

- WHO will support the Government to articulate innovative policies and approaches to human resource development and management.
- Following on from the Health Workforce Enhancement Plan, priority support will be given to the development of a Human Resources for Health Strategic Plan, focusing on strategies to increase the availability and actual deployment of health personnel with due consideration being given to mechanisms and incentives for attracting and retaining health personnel, especially at the primary care level.
- WHO will also provide technical support to developing a much-needed centralized human resources for health information system to underpin personnel planning and management.
- WHO will provide support to review the existing legislation and practices to improve health professional regulation, compliance and monitoring.
- Access to continuing education, including in-service refresher and extension training, is essential to ensure quality health service delivery, particularly in rural health facilities, and to enhance motivation of health workers. WHO will work with the Government to further develop strategies in this area.
- WHO will also provide support to the education sector and training institutions to improve and harmonize the curricula of health-related training programmes.

FOCUS AREA 3: Access to essential medical products

Ensuring access to essential medical products and reforming the medical supply system are longstanding concerns of the NDOH and its development partners. After initially promising improvements, largely attributed to the introduction of 100% medicine kits, policy reversals required a rethink and renewed efforts to improve availability of medicines and health technologies.

- To strengthen equitable access to good-quality, safe and affordable medical products, WHO aims to build regulatory system capacity for medical products throughout their life cycle, including pre-market evaluation of medical products.

- The establishment of a national medicines quality control laboratory will be supported with technical assistance on infrastructure, equipment, human resources, and training of laboratory analysts. Regarding medicines safety, a pharmacovigilance programme and drug information centre will be supported to collect, monitor and analyse adverse events reports from health facilities.
- WHO will support the national regulatory capacity on licensing, inspection and enforcement of law on pharmaceutical establishments such as wholesalers, packers, distributors and operators of pharmacies.
- To implement the National Health Policy Strategy of phasing out the 100% medical kit system and building capacity to implement a pull (demand) system, WHO will support capacity-building in procurement and supply chain management.

FOCUS AREA 4: Health information system

The reliability of health data remains problematic. Data analysis, information use and feedback to lower levels is insufficient, and lack of capacity at all levels is a major challenge.

- WHO will work with the Government to enhance accountability within the health sector through strengthening the National HIS at all levels. Parallel health information systems currently functioning within the sector will be harmonized and integrated.
- Support will be provided to improve the generation, analysis and use of quality and timely information, not just for evidence-based planning but also for making decisions and adjustments to service delivery approaches.
- The extended use of performance-based contracts to ensure attainment of minimum standards and underpin accountability will require improved information on activities and service outputs.
- Lessons learnt from the Rural Primary Health Service Delivery Project, particularly in regard to innovative information and communications technology solutions, will be taken into consideration in future developments of health information and performance management.

STRATEGIC PRIORITY 3

Emergency preparedness, surveillance and health security

FOCUS AREA 1: Disaster preparedness and response

With its location in the tropics and on the Pacific Rim of Fire, Papua New Guinea is prone to virtually all types of disasters, including volcanic eruptions, earthquakes, tsunami, tropical storms, landslides and flooding. In 2015, Papua New Guinea began to feel the effects of one of the worst El Niño climatological disturbances in history, resulting in widespread drought with dire consequences for hygiene and food security.

WHO provides technical support to the NDOH and other relevant stakeholders in emergency and humanitarian response. It does this primarily through its coordination of the Health Cluster in Papua New Guinea. The Cluster System is a coordination mechanism that helps the Government, NGOs, donors and other development partners to collaborate on specific subject areas related to natural disasters and other humanitarian emergencies.

Over the next five years, WHO will support the Government with the following:

- Enhancing the capacity of the NDOH in disaster risk management. As there are currently no trained and dedicated staff at the NDOH for dealing with the public health consequences of disasters, there is a need to advocate for this capacity, and enhance the links with national disaster management authorities. At the national level, WHO will present and discuss the Regional Framework for Action for Disaster Risk Management for Health, and facilitate the discussions on identifying priority actions and priority geographical areas with high risk of exposure to specific hazards. WHO will then support the designated disaster risk management for health national staff in working with selected priority provincial health offices in developing and implementing emergency preparedness plans.
- Health Cluster coordination. WHO will continue to provide a coordination platform for all partners working on health in emergencies. This includes regular meetings of Health Cluster partners, mapping of support, and identification of gaps through “who, what, where” matrices and other information management tools, support with rapid needs assessments, resource mobilization, and capacity development in preparedness and contingency planning.
- Enhancing surveillance of the impact of disasters on the health of affected persons. Through a holistic, integrated approach to surveillance for public health events of all types, WHO will support the NDOH to increase its network of surveillance sites and their capacity to rapidly detect the effects of disasters on health, with priority being given to areas at high risk of specific hazards and in the identified health

facilities considered “critical”, meaning that they are situated in a safe location and that they have the capacity to remain functional in the immediate aftermath of both sudden onset disasters and slow onset disasters.

FOCUS AREA 2: Surveillance and epidemics

Papua New Guinea is vulnerable to a wide variety of outbreak-prone diseases. From July 2009 until late 2011, Papua New Guinea experienced the first outbreak of cholera recorded in the country, resulting in more than 15 500 cases and more than 500 deaths. More recently, the first recorded outbreak of chikungunya affected all 22 provinces in 2012 and 2013, and a measles epidemic occurred between 2013 and 2015. Complicating the detection and response to epidemics is the geographical remoteness and inaccessibility of the terrain, poor communications networks, low epidemiological analysis capacity, and a low capacity to respond to detected signals.

Within the framework of the Asia Pacific Strategy for Emerging Diseases, WHO provides technical assistance to the Government on:

- planning, organization and implementation of epidemiological services and the control of communicable diseases with an emphasis on epidemic diseases;
- coordinating epidemiological investigations of outbreaks of communicable diseases, including emerging and re-emerging diseases and neglected diseases;
- providing technical and managerial support to assist the national authorities to meet their requirements under the revised International Health Regulations (IHR) (2005); and
- working with the national authorities to develop, deliver and evaluate training programmes intended to strengthen core capacity in communicable disease surveillance and response.

Over the next five years, WHO will support the Government with:

- Papua New Guinea FETP. One of the best examples of WHO’s successful collaboration with the NDOH in recent years has been the establishment of the Papua New Guinea FETP. The resultant enhanced epidemiological capacity has allowed for more timely, high-quality and well-coordinated responses to a variety of public health needs throughout Papua New Guinea. Included in the FETP will be training for district rapid response teams. WHO will continue to provide support to this programme through mentorship of fellows, strategic planning, organization

of courses, coordination with other partners who support the programme, such as the United States Centers for Disease Control and Prevention, and financial support. By the end of five years, it is expected that the programme will transition to a residential model.

- Enhancement of surveillance capacity. Papua New Guinea currently faces challenges with receiving regular reports from the provinces on the urgently notifiable conditions (UNCs). Plans are underway to roll out a nationwide mobile phone-based surveillance system. At the same time, in line with reforms to the National HIS and an expansion of electronic HIS reporting, it is envisioned that there will be an opportunity over the next five years to develop an integrated disease surveillance system covering not only the UNCs, but all diseases of public health importance.
- Strengthening of IHR core capacities. WHO will work with Papua New Guinea to strengthen its capacities under IHR (2005), including infection prevention and control; laboratory capacity strengthening; and capacity development at points of entry.

STRATEGIC PRIORITY 4

Sector overview, policy dialogue and development cooperation

FOCUS AREA 1: Policy dialogue and implementation

Providing sound and coherent policy advice based on a comprehensive overview of the health sector in the highly decentralized environment of Papua New Guinea is an essential aspect of WHO's role. Given Papua New Guinea's traditional focus on the production of extensive policy documents and plans, WHO will support the agreed shift in emphasis towards implementation: tracking progress, identifying and addressing bottlenecks, and highlighting key challenges, such as the disconnect between national policy and the allocation and use of resources by authorities and stakeholders at different levels of the system.

WHO's role as a broker and convener provides a suitable platform to work with government and development partners, including NGOs and the private sector, to systematically review issues and identify courses of action, based on lessons learnt and findings from the many projects and analytical studies that are undertaken by a wide range of agencies and institutions.

The mid-term review and joint assessment of the NHP 2011-2020 stressed the need to define and implement priorities. It provides a new impetus for the NDOH to selectively prioritize issues and programmes that need to be urgently addressed, and to step back from trying to deal with all health challenges. This in turn should also guide WHO's work over the next five years and stimulate rethinking about which priorities to tackle.

FOCUS AREA 2: Effective development cooperation

WHO will continue to co-chair, with Australia's DFAT, the Health Development Partners Group, which has been expanded to involve a wider range of partners, including national and international NGOs. The Group's monthly meeting now also features a more strategic agenda for discussing key issues in the sector in addition to the traditional exchange of information. WHO also serves on a number of boards and committees and will continue to do so. Given the unusual situation in Papua New Guinea, where a single bilateral agency (DFAT) provides the bulk of development funding, WHO's close collaboration with DFAT creates a unique opportunity for WHO to provide sound technical leadership while taking into consideration the economic and political environment in which the health sector operates.

FOCUS AREA 3: Strategic communication

The health sector needs to do a better job of advocating health as a key part of national development. The health risks facing the nation – not just at times of epidemics and emergencies, such as the current drought – but also as a result of inadequate recurrent funding of existing and new rural health facilities, coupled with the slow and often delayed release of funding at the provincial and district levels, needs to be brought to the attention of powerful stakeholders. WHO can work with the NDOH and its development partners to develop simple and convincing messages to politicians, private sector corporations and other significant actors, regarding the health needs of the people of Papua New Guinea.

More generally, WHO will make greater use of social media, including Facebook, Twitter and Linked-In, to extend its influence and advocacy for health. More strategic use of local news media to address key issues and promote WHO's role as the leading international health agency will also be pursued.



5. Implementing the CCS: implications for the WHO Secretariat

The strategic agenda presented in Chapter 4 has clear implications for the mix and profiles of professional staff and the ways of working required to implement the programme effectively. Concomitant shifts also need to be effected in spending on activities. With the 2016–2017 Programme Budget (PB) already in place, shifts will be gradually introduced and implemented.

Table 3 presents an overview of CCS priorities linked to PB activity costs for the next two bienniums as well as existing and planned staff numbers and the distribution of professionals between core programmes and strategic priorities. The table highlights the following:

- At present, 30% of PB 2016–2017 is allocated to areas not identified as strategic priorities in the CCS. If the non-CCS priority aspects of reproductive, maternal, neonatal, child and adolescent health and the WHO Representative Office were excluded, the proportion would be higher. Arguably, 50% of the WHO Representative Office’s budget goes to administration.
- Health systems strengthening (HSS) has an allocation of 23.8% of the total PB 2016–2017 and 15.7% of the professional staff.
- The proposed shift for PB 2018–19 means that the share of the budget allocated to health systems strengthening will rise to 30% and the proportion of staff dedicated to health systems strengthening will increase to 28% by 2019.
- With the anticipated inclusion of noncommunicable diseases as part of Strategic Priority 1, the proportion the budget allocated to non-CCS priorities would fall to 13%.

- If 50% of the WHO Representative Office's budget is assumed to be dedicated to strategic priority 4, this represents 10% of total professional staff, and 6% of total PB 2016–2017.

In addition to introducing shifts in the allocation of human and financial resources, and ensuring the availability of a sufficient budget to cover planned activities, approaches to the provision of technical and analytical support to the country office not only by the WHO Regional Office and WHO headquarters, but also by external resource institutions and consultants need to be considered.

Placing the best people in the most demanding jobs is one of seven action areas identified during a regional exercise reviewing how to keep countries at the centre of WHO's work. In Papua New Guinea, this means that staff profiles, recruitment procedures and employment conditions would need to be adjusted accordingly. Two types of skills are required in the country office. The first is providing support to implementation; the second relates to undertaking critical analytical work and exercising influence in the policy dialogue and in defining strategic approaches. The second type of skills is in short supply and it is not easy to recruit staff for this challenging context in Papua New Guinea. Specific incentives that make working in Papua New Guinea more attractive need to be considered, e.g. a duration of assignment not exceeding 2–3 years and advanced career prospects linked to working in Papua New Guinea, pending good performance. In addition, suitable external support may be needed to complement the capacity and capabilities in the country office.

Table 3: Overview of CCS priorities linked with current and future PB (activity costs) and staff (professionals including National Professional Officers (NPOs)) allocations

CCS priorities (non-priorities shaded)	Programme Budget (PB) Priority Programmes ¹	PB 2016-17 excluding staff ACTUAL	%	PB 2018-19 excluding staff PROJECTED	%	Professional posts 2015 ACTUAL	Professional Posts 2017 PROJECTED	Professional posts 2018 PROJECTED
SP1 TB/HIV	P1 + P2 ²	680 000	10.2	630 000	9	2 (TB only)	2 (TB only)	1 (TB only)
AIDS	P1	210 000	3.1	140 000	2	2 (HIV/AIDS)	2	1 HIV (could be NPO)
Malaria (surveillance only)	P3	506 686	7.6	280 000	4	1	2	1
Neglected tropical diseases (NTDs)	P3	120 000	1.8	70 000	1	1 NPO	(incl. 1 NPO)	(could be NPO)
Noncommunicable diseases (NCDs)	P5	490 000	7.4	630 000	9	0	0	1
SP1 Immunization	P4	377 070	5.6	490 000	7	1	1	1
SP1 Maternal and newborn mortality ³	P6	535 172	8.0	560 000	8	2	1	1
Gender, equity, human rights	P7	675 000	10.1	420 000	6	1 (NPO)	1 (NPO)	1 (NPO)
SP2 District health systems	P8	485 000	7.4	1 120 000	16	1	2	3
SP2 Human resources for health	P8	250 000	3.7	280 000	4	1	1	1
SP2 Access to medicines	P9	645 359	9.7	420 000	6	1	1	1
SP 2 National Health Information System (HIS)	P8	200 000	3.0	280 000	4	0	0	0
SP3 Disaster preparedness	P10	700 607	10.5	840 000	12	2 (incl. 1 NPO)	2 (incl. 1 NPO)	2 (incl. 1 NPO)
SP3 Surveillance	P10							
SP4 All focus areas	WHO Office Representative ⁴	792 540	11.9	840 000	12	4 (incl. 1 NPO)	4 (incl. 1 NPO)	4 (incl. 1 NPO)
Totals		6 667 434	100%	7 000 000	100%	19	19	18

¹ P1, HIV/AIDS; P2 TB; P3, Malaria and NTDs; P4, Vaccine-preventable diseases; P5, NCDs; P6, Reproductive, maternal, newborn health and childhood diseases (RMNCD); P7, Gender, equity and human rights; P8, Health services; P9, Access to medicines; P10, Alert and response capacities.

² The HIV/AIDS PB activity cost is assumed to be evenly divided between HIV and AIDS for purposes of allocation to CCS Strategic Priority 1 (SP1).

³ Although the focus is on maternal and newborn mortality, this table uses the total activity budget for reproductive, maternal, newborn, child and adolescent health.

⁴ The entire WHO Office Representative/administration budget is included although not all of it is devoted to the SP4 focus areas.

Country-focused and demand-led support from the WHO Regional Office and headquarters is needed and welcomed. To be effective, technical support visits need to be longer than is presently the case and should ideally take the form of a series of follow-up visits. More frequent teleconferences between the technical teams in the regional office and the country office to discuss issues and provide inputs based on broader-based regional and global experience are another way of improving and deepening support.

External resource institutions and consultants, preferably from WHO collaborating centres will be contacted with a view to providing support through intermittent visits over a one- to two-year period, thereby ensuring greater continuity and coherence in providing backup. This type of support should not only produce technical work of excellence, but also include on-the-job mentoring or coaching of both country office and NDOH staff.

Teamwork will be further encouraged, focusing particularly on the interaction between health outcomes and health systems programmes. The observation that staff tend to work in silos is long-standing and every effort will be made to address this issue and foster greater collaboration within and between teams. The WHO Representative Office has a significant role to play in ensuring cross-fertilization (see also below).

Strengthening the WHO Representative Office to perform the leadership and overview function is envisaged under Strategic Priority 4 as described in Chapter 4. Cooperation with other development partners has already been expanded and strengthened. Further staff and consultant resources may be needed to undertake the analytical and advocacy work that underpins sound policy dialogue. Strategic communications are an essential part of the responsibility of the WHO Representative Office. To this end, in addition to an already recruited National Professional Officer in this area, advice and inputs from communications experts will be required.

The mid-term evaluation is a critical event in the lifespan of a CCS. The concept of the CCS being a “live document” underpins the need for assessment of any changes that have taken place in the country context, progress made in implementing strategic priorities, lessons learnt so far and adjustments of the priorities and ways of working in response to findings. If significant shifts are indicated, this would require some flexibility in revising PB 2018–2019 which will precede the CCS mid-term review.

Donor funds constitute a significant proportion of the WHO country office’s total budget. A large proportion of the external funding comes from a single donor, Australia’s DFAT. Any significant reduction in these inputs would adversely affect the capacity of the country office to implement the intended programme of work, requiring cuts to activities and outputs, and thereby reducing the potential benefit and impact of WHO’s work.

ANNEX 1. People consulted

Papua New Guinea National Department of Health (NDOH)

Pascoe Kase, Secretary of Health
Elva Lionel, Deputy Secretary
Paison Dakulala, Deputy Secretary
Sibauk Bieb, Executive Manager, Public Health Division
Ken Wai, Executive Manager, Strategic Policy

Development partners

Australian Department of Foreign Affairs and Trade (DFAT)
Christine Sturrock, Counsellor, Health and HIV, DFAT
Lara Andrews, First Secretary, Development Cooperation
Catherina Habon, Program Manager Health and HIV, DFAT

USA agencies

Joanne Atkinson, Health Advisor, United States Agency for International Development (USAID)
Steven Terrell-Perica, Director, Centers for Disease Control and Prevention (CDC)
Percy Pokeya, HIV Senior Advisor, CDC

World Bank

Xiaohui Hou, Senior Health/Economist, World Bank, Sydney
Pranita Sharma, Public Financial Management Specialist
Kerry Main Pagau, Senior Human Development Specialist

United Nations

Walter Mendonca-Filho, Representative, United Nations Population Fund (UNFPA)
Baba Danbappa, Country Representative, United Nations Children's Fund (UNICEF)
Hemansu-Roy Trivedy, United Nations Resident Coordinator
Stuart David Watson, Country Director, Joint United Nations Programme on HIV/AIDS

Nongovernmental organizations

Curt von Boguslavski, Country Director, World Vision
Ingrid Glastonbury, Oil Search Foundation

Church Health Services

Joseph Sika, Chief Executive Officer

Bernard Rutmat, Deputy Chief Executive Officer

Others

Don Matheson, Team Leader, Mid-Term Review of the Papua New Guinea National Health Plan (by Skype)

Alessandro Loretto, WHO Consultant, Disaster Response (El Niño)

Julian Bilous, WHO Consultant, Immunization

Svend Muller, Consultant, National Economic and Fiscal Commission

ANNEX 2. Key documents reviewed

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